A Plan of Action for Improving the Oral Health Status of Michigan Residents

November 1, 2004

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Introduction

"I can see clearly now the rain is gone. I can see all obstacles in my way." -- from the song *I Can See Clearly Now* by Johnny Nash

This simple phrase summarizes the status of oral health in Michigan. While we know there are obstacles, we can see them and as a result, plan for how to overcome them. The recent creation and continuous expansion of the Michigan Oral Health Coalition has brought with it momentum to move oral health to the forefront of policy discussions. The connection between oral health and systemic health is beginning to be recognized by not only policymakers but also the public at large. The coalition, as well as multiple trade associations and advocates, have identified that oral health is integral to primary health care and have been actively communicating this statewide. As a statewide community, we now know where we are going and are preparing for how to get there.

The Michigan Department of Community Health (MDCH) recognized the need for Michigan to develop a coordinated effort around improving the oral health status of residents and submitted a proposal to the Centers for Disease Control and Prevention build up the oral health infrastructure in Michigan and develop a state oral health plan. Michigan is now in the second year of this infrastructure project.

The Michigan Oral Health Coalition kicked off on December 11, 2003, with a full membership meeting. At this meeting, participants were welcomed by Ms. Janet Olszewski, the Director of the Michigan Department of Community Health. Director Olszewski stressed to the participants the important role of the coalition and the commitment of MDCH to adopt the five-year plan of action developed by the Oral Health Coalition. At the kick off participants also identified a mission, outlined important issues, and described oral health assets in Michigan.

Historically, oral health has not been considered an integral component of primary health care. We are working to change that. One of the main outcomes sought by coalition members is the statewide recognition that oral health cannot be separated, and is essential to consider if we are to improve the oral & general health status of Michigan's citizens.

The actions outlined in this paper are designed to improve the oral health status of Michigan's residents. Such a challenging task would not be possible without the work of many motivated organizations and individuals. This paper represents the work of an interagency coalition known as the Michigan Oral Health Coalition. Members of the coalition include:

- Advantage Health Centers — Detroit
- Alcona Health Center — Lincoln
- Baker College — Port Huron
- Baldwin Family Health Care — Baldwin
- Blue Cross Blue Shield of Michigan — Southfield
- Capital Area Health Alliance — Lansing
- Capital Area Community Services, Inc.— Lansing
- Center for Family Health — Jackson
- Cherry Street Health Services — Grand Rapids

- Children's Hospital of Michigan — Detroit
- Delta Dental Plan of Michigan — Lansing
- Dental Clinics North — Charlevoix
- Detroit Community Health Connection — Detroit
- Family Health Center of Battle Creek — Battle Creek
- Family Independence Agency — Lansing
- Hackley Community Care Center — Muskegon Heights
- Hackley Hospital — Muskegon
- Hamilton Community Health Network — Flint
- Head Start—State Collaborative Program — Lansing
- Health Delivery Incorporated — Saginaw
- Henry Ford Health System, School Health Initiative — Detroit
- Hillsdale County Human Services Network — Hillsdale
- Ingham County Health Department — Lansing
- Ingham Oral Health Coalition — Lansing
- Intercare Community Health Network — Bangor
- Kalamazoo County Dental Clinic — Kalamazoo
- Lansing Community College Dental Hygienist Program — Lansing
- Marquette County Health Department — Marquette
- Medical Services Administration — Lansing
- Michigan Academy of Pediatric Dentistry — Flint
- Michigan Department of Environmental Quality—Water Division — Lansing
- Michigan Dental Hygienists Association — East Lansing
- Michigan Council for Maternal and Child Health — Lansing
- Michigan Dental Association — Lansing
- Michigan Department of Community Health — Lansing
- Michigan Department of Education — Lansing
- Michigan Health & Hospital Association — Lansing
- Michigan Health Council — Okemos
- Michigan Primary Care Association — Okemos
- Michigan Spit Tobacco Education Program — Lansing
- Mid-Michigan District Health Department — Stanton
- Mobile Dentists/Children's Dental Health Foundation — Farmington Hills
- Monroe County Health Department — Monroe
- Mott Children's Health Center — Flint
- Muskegon Community Health Project — Muskegon
- Muskegon County Health Department — Muskegon
- Muskegon Family Care — Muskegon
- Northwest Michigan Community Health Agency — Traverse City
- Northwest Michigan Health Services, Inc. — Traverse City
- Oakland/Livingston Human Serv. Agency, Child Dev. Division — Pontiac
- Omni Oral Pharmaceuticals — Kentwood
- Ottawa County Health Department — Holland
- Public Sector Consultants — Lansing
- St. Clair County Health Department — Port Huron
- Saginaw County Department of Public Health — Saginaw

- School-Community Health Alliance of Michigan — Okemos
- Sterling Area Health Center — Sterling
- Telamon Corporation — Lansing
- Tri-County Dental Health Council — Southfield
- University of Detroit Mercy School of Dentistry — Detroit
- University of Michigan School of Dentistry — Ann Arbor
- University of Michigan School of Public Health — Ann Arbor
- Washtenaw Children's Dental Clinic — Ann Arbor
- Wayne County Health Department — Wayne County
- Wolverine Dental Society — Detroit

Mission: To improve oral health in Michigan by focusing on prevention, health promotion, surveillance, access and the link between oral health and total health.

Key oral health assets and issues were identified at the kick off meeting of the Michigan Oral Health Coalition and were identified as follows:

Assets

- CDC grant for prevention
- A good supply of dentists, dental auxiliary, physicians and nurses (albeit mal distributed)
- Major universities with expertise to work with community partners
- Fluoridated water in many communities
- Grassroots coalitions in local communities
- Safety-net dental programs, including those at Federally Qualified Health Centers, local health departments and school based health centers
- Protection of oral health services for children through Early Periodic Screening, Diagnosis and Testing
- Education and business partnerships
- Health education in schools – Michigan Model (K-12) includes oral health
- Governor Granholm and her administration interested in oral health
- Media interested in health issues
- Strong third party payor structure
- Health professional students
- Passionate leaders and vision

Key Issues

- Lack of providers willing to serve low-income people and those with special needs
- Lack of a State Oral Health Officer
- Lack of public awareness of importance of oral health
- Lack of utilization of all dental professionals
- Lack of pediatric dental resources
- Provider mal-distribution
- Scope of practice limitations

- Lack of statewide data
- Lack of affordable services for uninsured
- Lack of Medicaid adult dental coverage
- Lack of oral health funding in general
- Lack of public/private funding for prevention strategies
- Insufficient payment rates

Participants then voted, as a way to guide deliberations, for those issues they felt were the most significant facing oral health in Michigan. The issues were divided among key topics and workgroups formed: Data, Prevention, Education and Awareness, Funding, Leadership and Workforce. The workgroups were asked to begin by addressing those issues of highest concern. Workgroup chairs were nominated and meeting participants identified workgroups in which they wished to participate. MPCA staff provided support to all workgroups in order to coordinate efforts between groups and provide documentation of their activities.

After the kick-off meeting, a steering committee of key stakeholders representing broad oral health interests and backgrounds was selected to guide the work of the coalition. The 10 member Steering Committee was comprised of the workgroup chairs and leaders within the oral health community. The committee met throughout the development of the plan to review preliminary work plans and meeting summaries from the workgroups to avoid overlap among workgroups and ensure that all grant objectives were being met. As the Steering Committee noted areas that could be strengthened, additional members were asked to join based on their areas of expertise.

The Oral Health Coalition has more than140 members who are involved in various workgroups. Five workgroups meet on a regular basis and are led by volunteer workgroup chairs. Workgroup sizes range between 10 and 22 members. The meetings have focused on the development of goals and objectives related to their specific area of focus. After four months of meetings, it was determined that the objectives of the Leadership workgroup could easily be folded into the activities of other workgroups and, as a result, discontinued. The final work plan includes the goals and objectives outlined by the remaining four workgroups.

In May 2004, the entire Michigan Oral Health Coalition reconvened to review each of the workgroups' draft work plans and oral health surveillance findings. Membership then worked together to establish the next steps for the coalition. The work plans were then incorporated into the Plan of Action, presented to the Steering Committee, the workgroups, and then the full coalition for review and approval. After the coalition has approved the draft plan, it will be shared at three community meetings across the state in order to gain feedback. These suggestions will then be reworked into the final Plan of Action for approval by the Oral Health Coalition and the Michigan Department of Community Health.

Strategies to Identify Best Practices

Workgroups will continue to convene as necessary to implement each of the activities outlined in the Plan of Action. They will also continue to identify best practices that can be replicated in Michigan and share practices that may be helpful to other states through continued collaboration with the Association of State and Territorial Dental Directors (ASTDD) and the CDC. Workgroups have identified best practices that they will be implementing in their work plans.

For example, the workforce work plan has proposed to research approaches used by other states to address access issues with current workforce.

Implementation Strategies, Leveraging of Resources, Partnerships, and Plan Maintenance
The Michigan Oral Health Coalition is fortunate enough to have more than 140 individual partners with a broad range of experience who are eager to begin implementation of the plan. Responsible individuals or organizations have been identified in the plan as the lead to ensure that action steps are accomplished. Workgroups will continue to meet as necessary to monitor their progress and identify and if appropriate incorporate new research initiatives. The MDCH Oral Health Program Coordinator will act as a liaison between the coalition and MDCH. Progress on the implementation of the plan will be reported at the annual conference and coalition meeting hosted by MDCH and MPCA.

Many of the coalition partners have committed local resources to implement various components of the action plan. For example, the Michigan Dental Association has volunteered to spearhead the statewide oral health campaign each February. Many other activities can be accomplished utilizing existing resources. The Oral Health Coalition will continue to examine resources at the state and local level that may be leveraged in order to complete the outlined objectives.

Healthy People 2010 Objectives & Evaluation Strategies for Monitoring the Outcomes and Impacts of Plan Implementation
An evaluation committee convened by the Michigan Department of Community Health will periodically evaluate the effectiveness of the coalition. The surveillance provided by the Data Workgroup and the monitoring mechanisms identified in the action plan will serve as key evaluation tools in monitoring the effectiveness of coalition activities. The Oral Health Coalition Workgroups will work with MDCH to provide continuous reporting on the oral health status of Michigan residents and present this information as well as reporting progress on the impact of prevention interventions annually during the annual Oral Health Coalition meeting each June. The surveillance plan includes each of the Healthy People 2010 Oral Health Objectives, which will be continuously monitored for improvement. Status on meeting each of the Healthy People 2010 objectives will be provided annually the Michigan Department of Community Health evaluation committee.

Oral Health and Systemic Health

One of the primary areas of focus of the Michigan Oral Health Coalition is recognition of the connection between systemic health and oral health. Inattention to oral health has important implications for our ability to reach current and future health outcome goals. Poor oral health has effects on pre-term births/low birth weight babies, diabetes control, heart disease and respiratory disease.

National Institute of Health funded studies estimate that as many as 18% of the 250,000 premature babies born weighing less than 5.5 pounds in the United States each year are due to periodontal infection (NIDCR, 2004). Pregnant women with periodontal disease may be seven times more likely to have a baby who is born too early or too small (AAP, 2004).

Recent studies point to an increased risk of heart disease and stroke in people with periodontal disease. The risk increases with the severity of infection. Heart disease is the leading cause of death in Michigan (MDCH, 2003).

Numerous studies have shown the impact periodontal disease can have on diabetes. People with diabetes are twice as likely to have periodontal disease (ADHA, 2003). Periodontal disease makes it more difficult to control blood sugar levels, and badly managed blood sugar levels can make periodontal problems worse. The Michigan BRFSS found that 41.8% of individuals with diabetes had lost 6 or more teeth in 2002 compared to 15.2% for those without diabetes (MDCH BRFSS, 2003)

Many systemic diseases have oral manifestations and can inform clinicians of the need for further evaluation. The oral cavity can also be adversely affected by many pharmaceuticals and other therapies commonly used in treating systemic conditions. Finally, individuals such as immunocompromised and hospitalized patients are at greater risk for morbidity due to oral infections.

Oral Health Status of Michigan Residents

Oral Health Infrastructure

The Michigan Department of Community Health (MDCH) recognized the need for Michigan to develop a coordinated effort around improving the oral health status of residents and submitted a proposal to the Centers for Disease Control and Prevention. Michigan is now in the second year of this infrastructure project. The previous two-year planning grant focused on the development of a baseline oral health assessment and assessing Michigan's current oral health surveillance tools. Another area of focus the first two years was providing training, consultation and technical assistance to communities on conducting an oral health capacity/staffing assessment, conducting a validation survey of services for children less than 20 years of age and utilizing data in program planning.

The first year of the current 5 year (Fiscal Year 04 to Fiscal Year 08) proposal focused on the formation of a coalition. The coalition is responsible for the development of a five-year plan to improve oral health and compilation and analysis of data available to implement a statewide oral health surveillance system. These activities began in July 2003. A part-time oral health epidemiologist was hired at MDCH to begin working on the surveillance system and MDCH contracted with Michigan Primary Care Association (MPCA) to develop and facilitate the activities of the Oral Health Coalition.

Michigan had been without an Oral Health Program Coordinator at the Michigan Department of Community Health for two years, until September 2004. The lack of a statewide coordinator to spearhead statewide efforts has left a considerable gap in the state. An oral health coordinator was hired in September, 2004 which should aid in the coordination of services in the state.

In 1991, the Michigan Department of Community Health, with the assistance of an interagency workgroup, developed the Michigan Oral Data (MOD) System as a tool to provide a dental disease profile of the population served in the participating publicly funded dental clinics. The system involves the collection of caries, untreated decay and several other oral health indicators.

Currently 11 dental clinics in Michigan collect oral health data using this system. The MOD System is not population based or statewide, but, data from the system can provide some insight on the status of oral disease and may be a useful component of the statewide oral health surveillance system. Efforts continue in order to expand the number of clinics in Michigan who collect oral health data using the MOD system.

In the future, the Michigan Oral Health Coalition is examining the use of an additional source of oral health data. The Basic Screening Survey (BSS) is a statewide and population based oral data collection tool. The BSS is a standardized set of forms developed to collect information on the observed oral health of participants of all ages. The survey notes the presence of untreated decay and the urgency of need for treatment of all ages and edentulism in adults.

There is concern that the oral health infrastructure for underserved individuals in Michigan and the health status of residents is at risk. Oral health services for adults on Medicaid, beyond emergency care, were eliminated as of October 2003. With the elimination of the benefit more than 600,000 adults in Michigan lost access to oral health care.

Description of Priority Populations, Burden of Disease & Caries

Dental caries (tooth decay) have been considered the single most common chronic childhood disease. According to the MOD System findings, approximately one in six underserved children had evidence of early childhood caries. Among 6-to 12-year old children, 46.3% had caries experience in their permanent teeth and 30.8% had untreated permanent tooth decay. An average of 2.9 permanent teeth had decay among children with caries experience. The rate of caries experience in permanent teeth is dramatically higher among underserved adolescents at 82%, with 54.6% having untreated decay (MDCH, 2004). It is difficult to make direct comparisons to national caries data for these age breakdowns; however, national numbers can be found in Figure 1.

The MOD System also indicated poor oral health status for underserved adults. Two-thirds of adults ages 20-64 had untreated permanent tooth decay and 55.6% had lost at least one tooth due to caries experience or periodontal disease (MDCH, 2004). In comparison, the CDC estimates that nationally approximately one-third of poor adults 18 and over have untreated decay in a permanent tooth (CDC, 2004). The Michigan system also found that nearly one in six of the adults had root caries experience.

The coalition proposes ongoing surveillance of caries experience in both children and adults. Other activities geared at reducing the incidence of caries include providing education on oral health throughout the lifespan, supporting efforts of MDCH to implement a school-rinse program and school-based sealant program, and improving access to preventive care for underserved populations.

Early Childhood Caries (ECC)

The 2003 Michigan Child Dental Coverage Validation Survey reported that among all children under age four, 29.3% had been put to bed at least occasionally with a bottle of juice, formula, milk or other liquid besides water (Eklund, 2003). The validation survey found there were significant differences based on the age and ethnicity of the respondent. Respondents under age

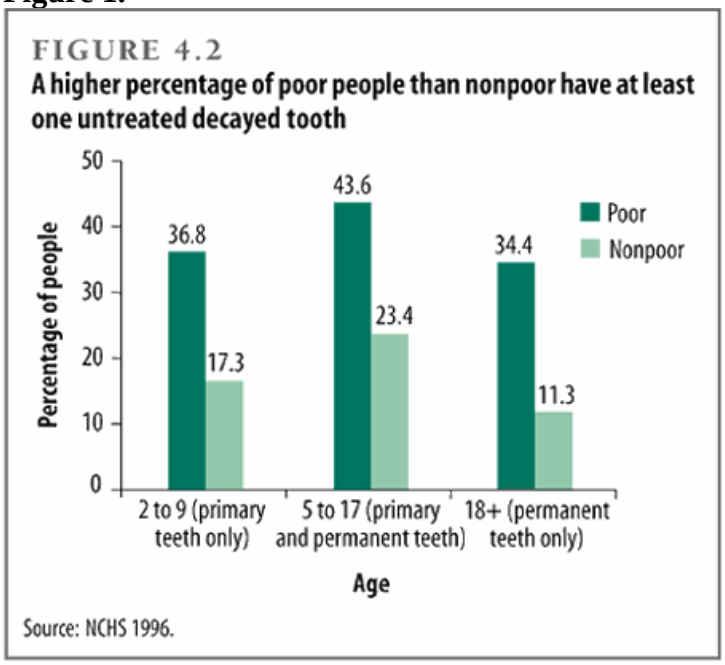
30 were much more likely to report this having been done at least occasionally (41.4%) compared to those respondents 30-39 years of age (18.9%). Hispanic respondents also reported a higher rate than non Hispanics, 76.5% compared to 27.3%, of occasionally putting children under age four to bed with a bottle of liquid other than water.

Disparities

One of the greatest disparities in oral health is by income. According to the U.S. Surgeon General's Report, A National Call to Action to Promote Oral Health (2003), poor children suffer twice as much dental caries as their more affluent peers and their decay is more likely to be untreated.

The following figure from Oral Health in America: A Report of the Surgeon General demonstrates oral health disparity by income in the United States.

Figure 1.



The 2002 Michigan Behavioral Risk Factor Surveillance System (BRFSS) (MDCH BRFSS, 2003) provides additional estimates regarding oral health status and behaviors of Michigan residents. The BRFSS estimates prevalence of certain behaviors, conditions and practices in Michigan adults and these estimates are based on data collected from a random-digit dial telephone survey of Michigan households. This system is designed to be statewide and population based, and in comparison, is much broader than the MOD system utilizing information from 11 clinics. The 2002 BRFSS demonstrated that 47.6% of individuals with household incomes below $20,000 had not visited a dentist in the previous year. In contrast, only 15.9% of individuals with household incomes between $50,000 and $74,999 had not visited the dentist within the previous year.

Closely connected to income, level of educational attainment similarly impacts the status of oral health care in Michigan. According to the 2002 BRFSS among those individuals with less than a high school education only 51.2% received dental care in the previous year, compared to 86.4% for college graduates.

Racial disparities are also evident in oral health status. According to the 2002 Michigan BRFSS, 35.1% of individuals who had identified themselves in the survey as black had not visited a dentist in the previous year, compared to 21.4% for individuals who had identified themselves as white. Michigan also experiences higher rates of oral cancer incidence and mortality among African-Americans.

Oral Cancer, Periodontal disease and Infection Control

Oral Cancer

According to the University of Michigan, School of Dentistry's 2003 report Epidemiology of Oral Cancer in Michigan, while the oral cancer mortality rate in Michigan is slowly decreasing and is lower than the national average, certain populations are disproportionately impacted. The report indicated the Michigan oral cancer mortality rate from 1990-1999 was 2.9 per 100,000 persons compared to the national rate of 3.2 per 100,000 persons.

The report further explained that Michigan males had much higher oral cancer incidence and mortality rates than females during the 1990s. African-American males had the highest oral cancer incidence and mortality rates among all races and gender groups. The incidence rate of oral cancer in African-American males of 25 per 100,000 individuals was 1.5 times higher than the rates of the white males and 3.6 times higher than the rates of the African-American females. The attached Plan of Action outlines activities aimed at improving the oral cancer mortality rate and the disparities that exist.

The Data Workgroup and the MDCH Oral Health Epidemiologist will investigate options to measure periodontal disease in Michigan. Measures to improve oral health status and reduce periodontal disease are identified throughout the Plan of Action, including education on the importance of oral heath care and improving access to care for un-served populations.

All individuals involved in clinical activities related to the work of the coalition will be educated on the CDC's Guidelines for Infection Control in Dental Health-Care Settings (2003). Information on statewide trainings on infection control in the dental setting will be widely distributed to coalition partners. MPCA will also propose hosting a session on Infection Control at the Annual Michigan Oral Health Conference in which continuing education credits are made available.

Diabetes

Studies have shown several relationships between oral health and diabetes. In Michigan, the 2002 BRFSS found that persons with diabetes were much more likely to have lost six or more teeth than those without diabetes (MDCH Diabetes 2004). Nearly forty-two percent of those with diabetes lost six or more teeth compared to just over 15% for those without the disease.

Access to care

While certain populations in Michigan are able to access dental care easily in their community, there are many for whom access to dental care is extremely limited. The oral health disparities in the United States due to these access barriers are vast. The 2003 Michigan Child Dental Coverage Validation Survey reported that for individuals three years of age and older, 83.8% of the children had seen a dentist within the past 12 months. The survey demonstrated that those without dental insurance are twice as likely to have never visited a dentist as were those with insurance. Of the children without dental insurance, 11.2% had never visited the dentist compared to 5.2% for those with dental insurance (Eklund, 2003).

Michigan established a State Children's Health Insurance Program (SCHIP), MIChild, a program offering insurance for children who are uninsured and not eligible for Medicaid. The MIChild dental program has had great success in provider participation and in the number of children utilizing dental care. The increased provider participation has been attributed to increased reimbursement levels and decreased administrative burden.

Michigan also has a dental demonstration project in 37 of Michigan's 83 counties called Healthy Kids Dental. The program has moved the children who were in the traditional Medicaid dental program into this state-private dental partnership. This was accomplished by purchasing the use of a private dental health plan that results in increased Medicaid reimbursement levels and reduces administrative difficulties. It has proven to be effective in increasing the number of children who receive dental care in the rural counties where it has been implemented by increasing the number of providers willing to care for the patients.

Thirty percent of Michigan's children were enrolled in Medicaid in 2002. Only 23% of Medicaid enrolled children ages 0-19 received a dental visit during that same time period. Of all Michigan children, including those on Medicaid, 51% had a dental visit during that same year. Figure 2 depicts the proportion of Medicaid enrolled children who had at least one dental visit in 2002. Figure 3 depicts the proportion of all Michigan children who had at least one dental visit in 2002 (Eklund, 2003).

Strategies to address Oral Health Promotion across the Lifespan

The Michigan Oral Health Coalition is focused on improving oral health throughout the lifespan beginning with proper prenatal oral health care and continuing through care in nursing homes and at home health facilities. Comprehensive oral health education resources will be developed for all ages and non-dental health care providers will be provided with information on the importance of oral health. The coalition will continue to build networks throughout the state to improve education on the importance of oral health for individuals throughout the lifespan and will aim to increase access to proven preventive practices that maintain optimal health for all ages.

Figure 2.

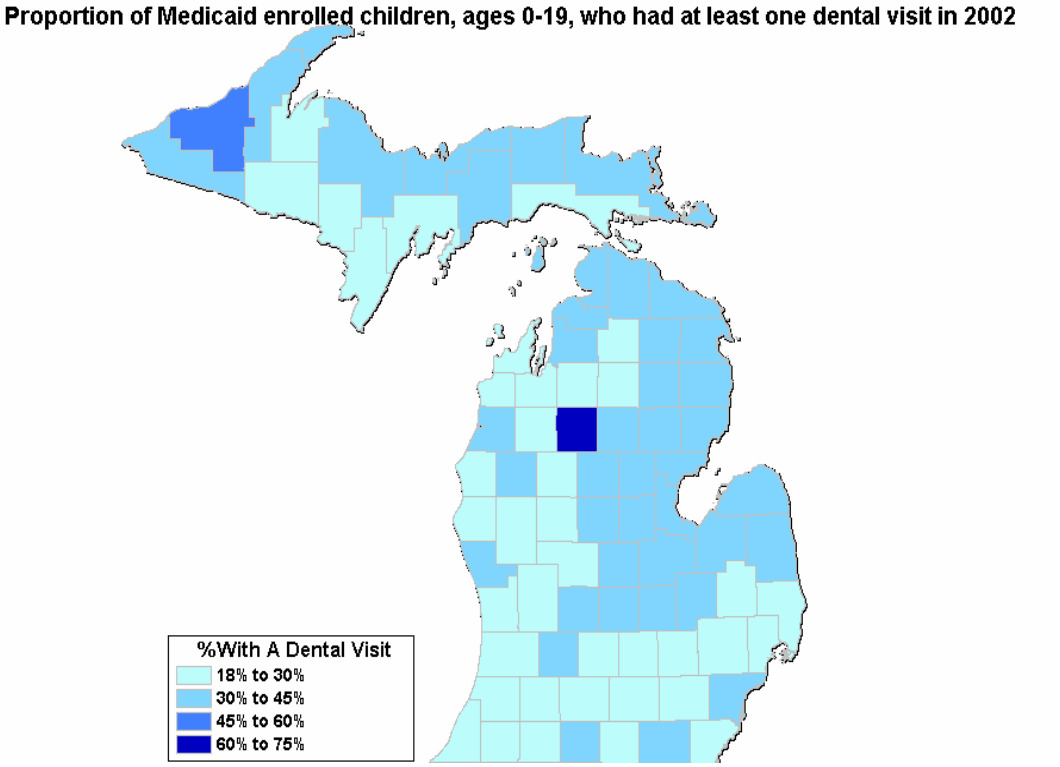
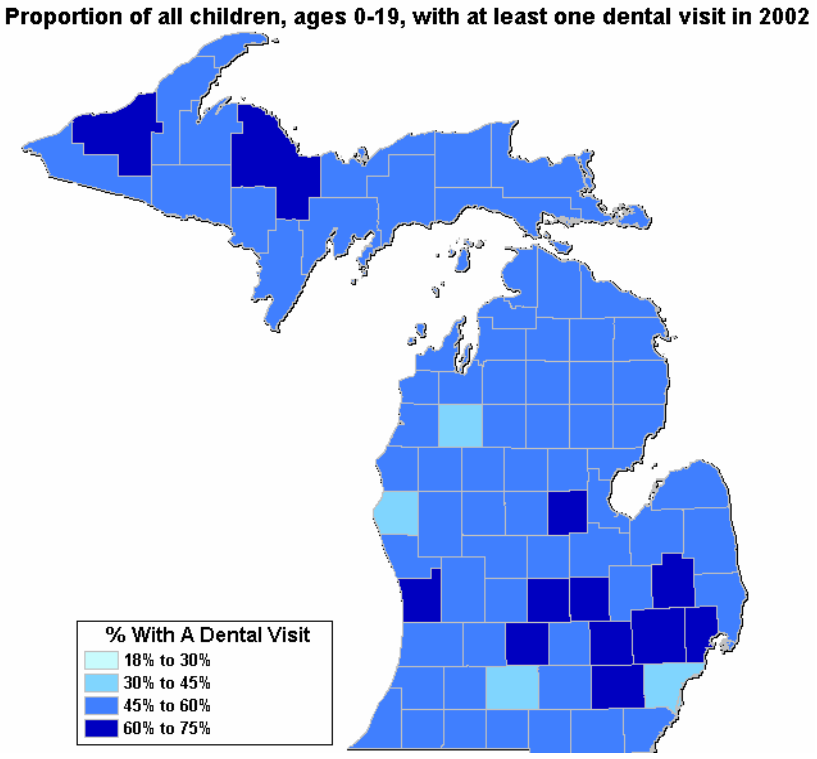


Figure 3.

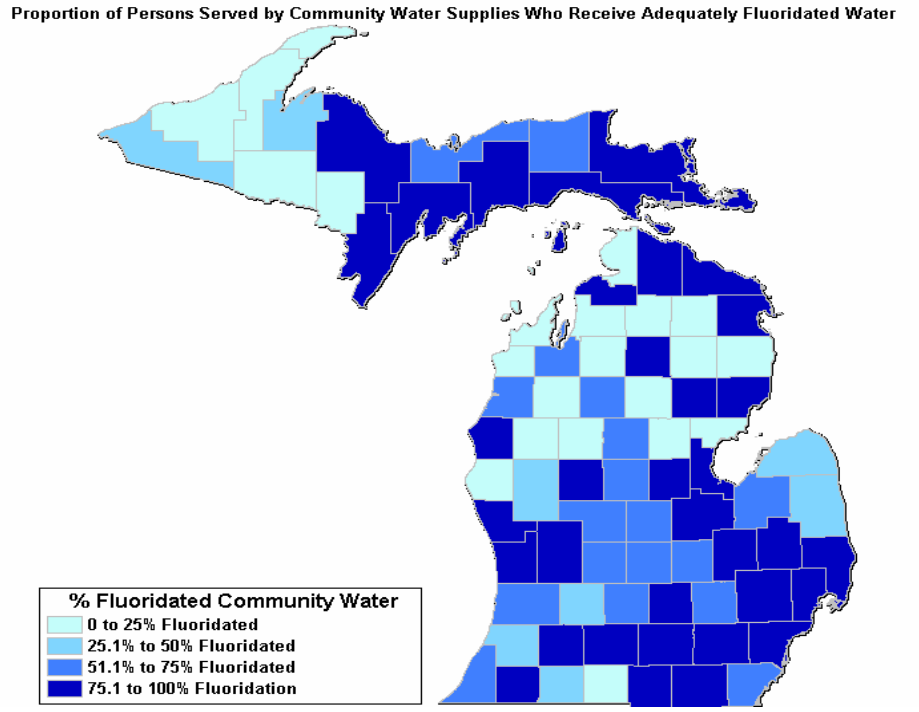


Water Fluoridation and School-Based or School-Linked Sealant Programs
Healthy People 2010-Oral Health proposes to increase the proportion of the U.S. population served by community water systems with optimally fluoridated water in order to reduce dental caries. As noted in *Oral Health in America: A Report of the Surgeon General*, community water fluoridation continues to be the most cost-effective, equitable and safe means to provide protection from tooth decay in a community.

In Michigan, 73% of the state's population is served by a community water system. Of the individuals served by community water, 89.4% are being provided with adequately fluoridated water. This equates to 65.3% of Michigan residents who are being served by a community water supply with adequately fluoridated water (MDEQ 2003). Nationally, 67% of the population served by public water supplies is provided with optimal fluoride levels for preventing decay (CDC, 2004).

Figure 4 shows the proportion of persons served by community water supplies who receive adequate fluoridation levels by county. Fluoride levels in Michigan will continue to be monitored and reported by the Michigan Department of Environmental Quality and, through coordination with the MDCH, Oral Health Program, the Water Fluoridation Reporting System (WFRS) will be encouraged. This system monitors the extent and consistency of water fluoridation.

Figure 4.



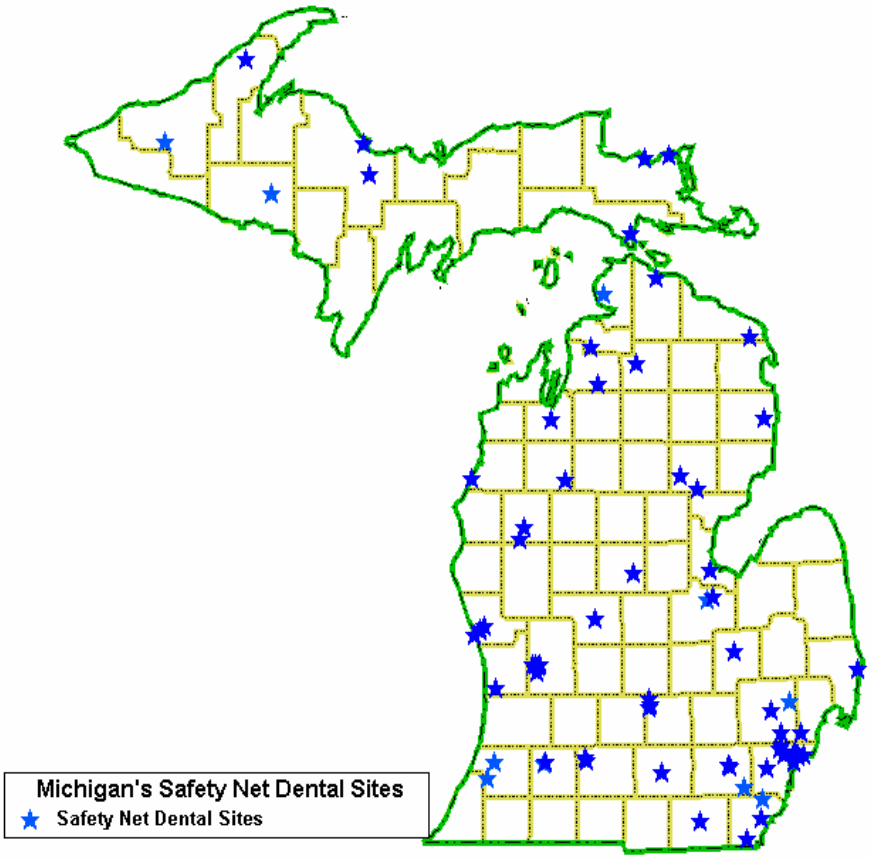
The Michigan Oral Health Coalition recognizes that sealants are an effective method to prevent tooth decay. The coalition supports efforts by the Michigan Department of Community Health to implement a school-based sealant program in conjunction with coalition partners, including the School Community Health Alliance of Michigan.

Publicly Supported Dental Clinics

Michigan currently has 75 community based, publicly supported dental clinics. The number of clinics grew in Fiscal Year 2000 when the legislature appropriated $10.9 million for a one-time oral health expansion grant. This grant allowed for the uninsured and Medicaid beneficiaries in many communities to access oral health services that had been desperately needed. However, with the elimination of the adult oral health benefits for Medicaid enrollees in 2003, and the increased number of persons without dental insurance, the infrastructure developed in 2000 is in jeopardy. Clinics are reducing hours, eliminating services, laying off dedicated staff. Some clinics have recently been forced to close.

The map below shows each of the publicly supported dental sites in Michigan today. The services provided at each site vary from cleanings to restorations. Some provide services to only children or adults, while others provide a full -range of oral health services to the community.

Figure 5.

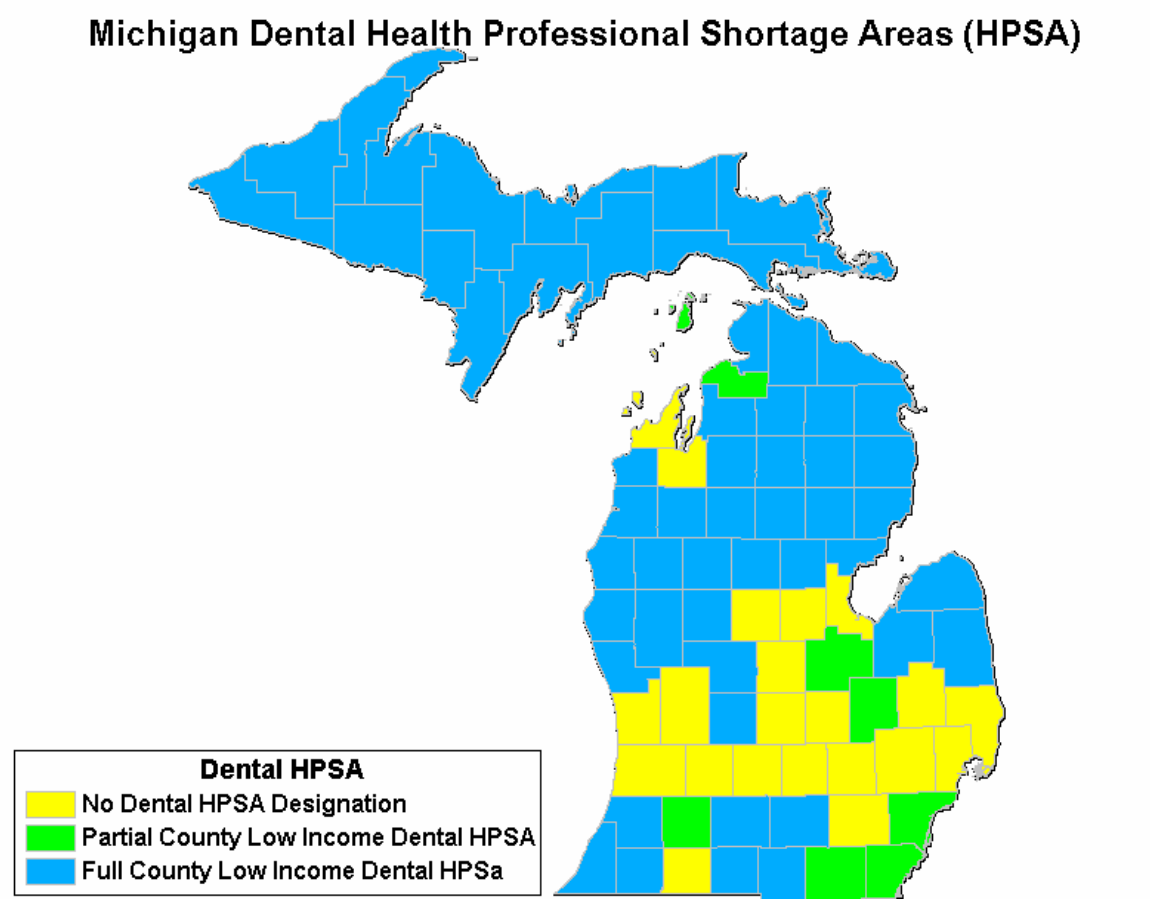


Dental Providers

According to 2004 MDCH dental licensing information, Michigan has 6,366 licensed dentists for an overall population to dentist ratio of 1,561 to 1 (MDCH Licensing, 2004). The overall population to dentist ratio is based on dentists licensed to practice in Michigan and is not adjusted for those who are not currently practicing in the state or who are working part-time.

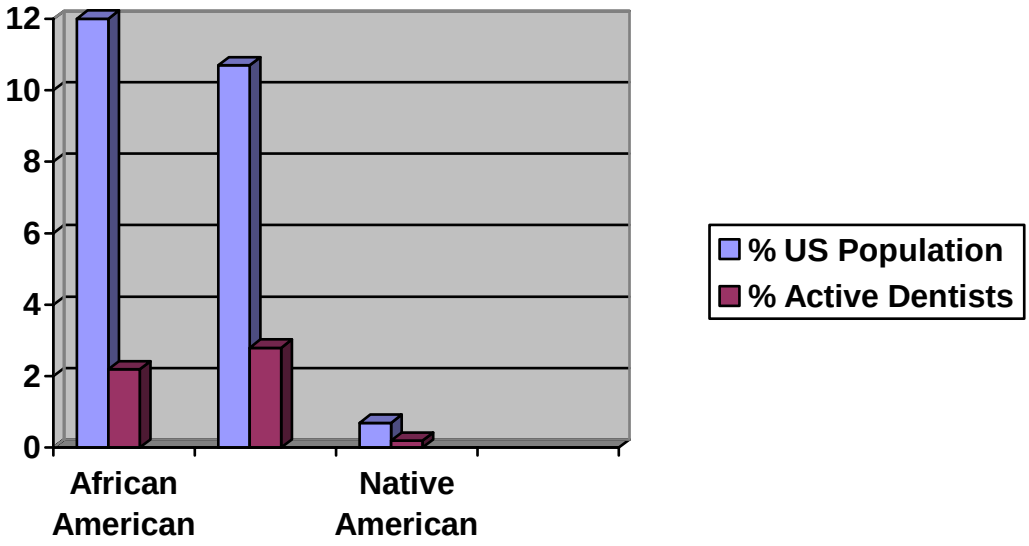
There is a shortage of providers willing to serve the low-income populations. According to the Michigan Department of Community Health, 8% of Michigan counties (7 out of 83 counties) have no enrolled Medicaid dentists (MDCH CDC, 2004). According to the same report, only 43% (36 out of 83) of the counties have only one enrolled Medicaid dentist with paid claims above $10,000 per year. Sixty-five out of eighty-three Michigan counties are designated as a full or partial Health Professional Shortage Area (HPSA) for low income and Medicaid populations. A map showing the Dental Health Professional Shortage Areas (HPSAs) by county can be found below (HHS 2004).

Figure 6.



Nationally, specific racial and ethnic groups are underrepresented in dentistry compared to their representation in the population. According to the document, A National Call to Action to Promote Oral Health, African Americans comprise 2.2 percent of active dentists versus 12 percent of the population; Hispanics comprise 2.8 percent of active dentists versus 10.7 percent of the population; Native Americans comprise 0.2 percent of active dentists versus 0.7 percent of the population (HHS, 2003). We believe a similar disparity exists in Michigan. The workforce workgroup is interested in exploring this further.

Figure 7.



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Summary of Recommendations

Data Workgroup

1. Develop a statewide oral health surveillance system to provide a routine source of actionable data.

2. Increase the sustainability of the statewide oral health surveillance system.

Prevention, Education & Awareness Workgroup

1. Increase access to proven prevention practices that maintain optimal health.

2. Develop a statewide education program aimed at increasing knowledge about the relationship between oral health and systemic health.

3. Make comprehensive oral health education resources should be available for all ages.

4. Increase the education of non-dental health care providers on the importance of oral health.

5. Encourage health care providers should discuss the oral effects of tobacco use (cigarettes, cigars, pipes and spit tobacco).

Funding Workgroup

1. Work with the Governor's Office and the legislature towards creation of a Medicaid adult oral health benefit that ensures access and is consistent with high quality of care standards.

2. Work with the Governor's Office and the legislature towards the creation of a Medicaid pediatric oral health benefit that ensures access throughout the State and is consistent with high quality of care standards.

3. Develop a system of care that ensures access to oral health services for low-income uninsured populations.

Workforce Workgroup

1. Increase access to oral health services in medically underserved communities and to medically underserved populations by allowing the provision of high-quality dental care through qualified health care providers.

2. Develop and support incentive programs to attract oral health professionals to underserved areas and to serve medically underserved populations.

3. Create and maintain a process for assessing and responding to supply and demand of the oral health workforce.

4. Develop a dental director leadership position to serve as the focal point of oral health activity for the state.

Action Plan Matrix for the Oral Health Plan of Action

Data Workgroup

Recommendation/Strategy: Develop a statewide oral health surveillance system to provide a routine source of actionable data.
Rationale: Routine surveillance will allow us to: 1) estimate the magnitude of oral health disease in Michigan, 2) monitor trends in oral health indicators, 3) evaluate the effectiveness of implemented programs and policy changes, 4) identify vulnerable population groups, and 5) provide information for decision-making when allocating resources.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
1. Explore options to measure the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth through the use of: A) claims data, and/or B) open mouth screenings.	A) Claims Data: Information from private insurers and Medicaid. B) Open Mouth Screening: These screenings would require volunteer dental staff and participation from schools, parent teacher organizations, and parents.	The Data Workgroup	Claims data would need to be validated with an open mouth screening. Consistency of caries measurement by dental providers would need to be standardized using a recommended calibration system.	Claims could be measured annually Surveillance through open mouth screenings could begin Sept. 2005 and frequency is yet to be determined.
2. Measure the	These screenings would	The Data Workgroup	Consistency of caries	Open mouth

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
proportion of children and adolescents with untreated dental decay by exploring the use of open mouth screenings.	require volunteer dental staff and participation from schools, parent-teacher organizations and parents.		measurement by dental providers would need to be standardized using a recommended calibration system.	screenings could begin Sept. 2005 and frequency is yet to be determined.
3. Measure the proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease.	BRFSS (Behavioral Risk Factor Surveillance System)	BRFSS Coordinator	BRFSS Response Rates	Annual
4. Measure the proportion of older adults who have had all their natural teeth extracted.	BRFSS	BRFSS Coordinator	BRFSS Response Rates	Annual
5. Investigate options to measure the prevalence of periodontal disease.	(NHANES) National Health and Nutrition Examination Survey.	The Data Workgroup	NHANES Response Rates	As conducted
6. Measure the proportion of oral and pharyngeal cancers detected at the earliest stage.	The State Cancer Registry and the Detroit Cancer Registry.	Collaboration with the Cancer Registries	Internal data quality assurance through the registry	Annual

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
7. Explore options to measure the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.	The BRFSS could be used to obtain patient oriented results or a DDS survey to obtain information from providers.	The Data Workgroup		As conducted
8. Explore options to measure the proportion of children who have received dental sealants on their molar teeth through the use of: A) claims data, and/or B) open mouth screenings. (BSS)	A) Claims Data: Information from private insurers and Medicaid. B) Open Mouth Screening: These screenings would require volunteer dental staff and participation from schools, parent teacher organizations and parents.	The Data Workgroup	Claims data should be validated with an open mouth screening. Consistency among dental providers would need to be measured using a recommended calibration system.	Claims could be measured annually Open mouth screenings could begin Sept. 2005 and frequency is yet to be determined.
9. Measure the proportion of the MI population served by community water systems with optimally fluoridated water.	The Michigan Department of Environmental Quality (DEQ) can provide information on community water supplies, including artificially fluoridated and the Environmental Protection Agency (EPA) provides information on naturally	DEQ and EPA	Internal monitoring mechanisms	Annual

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
	fluoridated community water supplies.			
10. Measure the proportion of children and adults who use the oral health care system each year through use of claims data.	Claims data from private insurers and Medicaid Adult information can be through the BRFSS for adults Care provided to the uninsured through safety net dental programs will also be examined.	The Data Workgroup and the BRFSS Coordinator		Annual
11. Measure the proportion of long-term care residents who use the oral health care system each year.	Minimum Data Set for Home Care Survey. Possible information from Medicaid as well.	Collaboration between the Community and Home-Based Waiver Program and the Data Workgroup.	This survey has been previously validated	Annual
12. Measure the proportion of low-income children and adolescents who received any preventive dental service during the past year.	Medicaid claims data	MDCH		Annual
13. Measure the proportion of school-based health centers with an oral health component.	Survey of School Based Health Centers	School Health Alliance		As Conducted (Every 2 years)

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
14. Measure the proportion of local health departments and community-based health centers, including community, migrant, and homeless health centers that have an oral health component.	The Oral Health Program Directory	MDCH, MPCA	Updated Annually	Annual
15. Measure the quality of the system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly rehabilitative teams.	The Birth Defects Registry	The Birth Defects Registry	Internal through the Birth Defects Registry	Annual
16. Develop an oral and craniofacial health surveillance system.	All oral health data resources available in the state	The Data Workgroup	Ongoing	Annual

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
17. Measure the number of Tribal, State including the District of Columbia), and local health agencies that serve jurisdictions of 250,000 or more persons that have in place an effective public dental health program directed by a dental professional with public health training.	The Oral Health Program Directory	MDCH	Updated Annually	Annual

Recommendation/Strategy: Increase the sustainability of the statewide oral health surveillance system.
Rationale: A surveillance system should be feasible, adaptable, representative and acceptable. A passive surveillance system should work towards minimizing resource costs while maximizing data quality and stability yet remain adaptable to changing needs.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism/Evaluation	Completion Date(s)/Frequency
1. Enlist the cooperation of dental insurance providers in obtaining information regarding utilization of dental services.	Dental Insurance Providers MDCH	MDCH	Participaton by Insurers and Quality of Information Provided	June 2005
2. Explore integration of technological alternatives to oral health screenings for future statewide surveillance measures. (e.g. the use of EMR)	Data Workgroup	Data Workgroup		Ongoing

Prevention, Education and Awareness Workgroup

Recommendation/Strategy: Increase access to proven preventive practices that maintain optimal oral health.
Rationale: There are a number of safe, proven methods to prevent dental caries, including nutrition education, sealants, water fluoridation and fluoride varnishes.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Support efforts by MDCH to implement a school rinse program in non-fluoridated communities.	Funding, coordinator	MDCH Oral Health Lead	School rinse program is implemented	Ongoing
2. Support efforts by MDCH to implement a school based sealant program.	Funding, coordinator, equipment, Local Health Departments and School-Based Health Centers	MDCH Oral Health Lead	School-based sealant program is implemented	June 2007
3. Support efforts by MDCH to implement the application of fluoride varnishes during the well child visits.	Ensure this is allowable under the scope of practice for physicians and nurses and check with insurance companies to insure that they will accept dental codes from medical providers.	MDCH	Fluoride varnishes are incorporated into well child visit.	December 2005

4. Evaluate the effectiveness for improving oral health by mandating an oral health exam prior to entrance into kindergarten.	Research on other areas that this has been done and its effectiveness.	Delta Dental MDCH	Study of effectiveness is completed	August 2006
5. Explore preventive practices for prenatal and postpartum oral health care.	Research of best practices	MDCH Oral Health Program Coordinator	Research completed and recommendations made to the coalition	June 2007
6. Provide training on the CDC's Guidelines' for Infection Control in Dental Health Settings.	The CDC Guidelines as a model, The Oral Health Conference as a training venue	MDCH Oral Health Program Coordinator	Training Provided	June 2006

Recommendation/Strategy: Develop a statewide education program aimed at increasing knowledge about the relationship between oral health and systemic health.
Rationale: Oral health is essential to systemic health. When developing health policy, oral health must be considered primary care.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Coordinate a Statewide Public Education and Awareness Campaign.	MDCH, Delta Dental, Blue Cross & Blue Shield, private industry partners, local broadcasting and other media	MDCH Oral Health Program Coordinator & partnership with insurers and private industry	Public Relations Plan and Campaign developed	CY 05 and then annually
2. Continue to build networks throughout the state to improve education on the importance of oral health for individuals throughout the lifespan, particularly for the elderly.	Partners: Michigan State Medical Society (MSMS), Michigan Osteopathic Association (MOA), Michigan Association of Health Plans (MAHP), MPCA, Michigan Dental Association (MDA), Michigan Dental Hygiene Association (MDHA), MDCH, Michigan Resource Center (MRC), Cancer Societies, Diabetes Associations, Dietitians, Maternal Support Services/Infant Support Services (MSS/ISS) groups, Michigan Department of Education (DOE), Delta Dental, Blue Cross Blue Shield, etc.	Oral Health Coalition and partners	Networking Continues	CY 04 and then ongoing

3. Coordinate a Statewide oral health observance for the month of February.	MDA, MDHA, MPCA, dental hygiene programs and other dental societies as well as educational institutions for materials. Delta Dental, BCBS and others for funding.	Michigan Dental Association	Annual observance is coordinated	CY 05 and then annually (February)

Recommendation/Strategy: Make comprehensive oral health education resources available for all ages.

Rationale: In order to increase awareness about the importance of oral health, age appropriate information should be provided to health professionals, parents, teachers, etc.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Partner with Head Start agencies in their project to ensure oral health education and prevention activities are available.	Curricula development, staff coordination	Michigan Head Start Association	Materials are available	December 2005
2. Identify existing health resource clearinghouses for dissemination of electronic information and written materials, particularly oral health. (i.g. the Prevention Resource Center)		MPCA	Existing resources identified	December 04
3. Identify funding for a clearinghouse of oral health materials that would direct people to appropriate resources.	Funding for staffing and technology, distribution of materials, etc.	MPCA	Funding is obtained	December 2005
4. Establish the clearinghouse for oral health.	Funding for staffing and technology, distribution of materials, etc.	MPCA	The Clearinghouse is established	May 2006
5. Provide information on the availability of the clearinghouse as a resource to health providers, educators, etc.	Brochures, web links to other commonly visited websites	MPCA, MDCH, The Michigan Education Association (MEA) Michigan's Surgeon General, Oral Health Coalition Members	Increase in the use of the clearinghouse.	May 2006 and ongoing

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
6. Work with the Department of Education to continue oral health modules in school curriculum.	The Michigan Model	Department of Education and MDCH	Oral health modules are continued	Ongoing
7. Provide oral health curriculum to day-care centers, Maternal Support Services/Infant Support Services (MSS/ISS) Providers, Women, Infant and Children (WIC) providers, School-based health centers and after school and summer care programs.		Department of Education and MDCH	Curriculum is provided	Ongoing

Recommendation/Strategy: Increase the education of non-dental health care providers on the importance of oral health.
Rationale: To optimize patient care by assuring that oral health is an integral component of primary care.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Ensure that annual trainings/continuing education opportunities are available annually for all health care providers on topics such as the following: - the relationship between oral health and maternal health; - the role that oral health can play with chronic diseases, such as diabetes; - the oral side effects of many medications; - the role of tobacco in oral health and screening; - screening and referral for early signs of decay in infants/children; - the relationships between oral health and systemic health; and - optimizing oral health in medically-compromised populations;	Staff, funding Make available speakers for health professional conferences such as those hosted by American College of Obstetrics and Gynecology (ACOG), American Academy of Pediatrics (AAP), Michigan Association of Family Practice (MAFP), American Association of Retired People (AARP), Society of Pubic Health Educators (SOPHE) SOPHE, MSMS, MOA, Michigan Nurses Association (MNA), MDCH, MOA, MPCA, MDA, Delta Dental, Blue Cross Blue Shield, etc.	MPCA	Trainings on the listed topics are available annually and a list of trainings are widely distributed across the state.	May 2005 and annually

	On line continuing education Website links on MPCA, MDA, MDCH, etc.			
2. Ensure that medical school and nursing school curricula include information on the interplay between oral health and physical health.	Staff time, Deans of Medical Schools	MDCH and MPCA	Information is included in the curricula	May 2006

Recommendation/Strategy: Encourage health care providers should discuss the oral effects of tobacco use (cigarettes, cigars, pipes and spit tobacco).
Rationale: There is a direct link between oral cancer and tobacco use.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1.Measure and improve the level of oral cancer knowledge in medical education.	Survey of medical schools and oral cancer curricula	MDCH Oral Health Epidemiologist	Survey completed	May 2005
2. Increase oral cancer screenings by all health care providers, including dentists and dental hygienists.	CEU Courses	Oral Health Coalition	Annual data collected by MDCH will indicate an increase in oral cancer screenings. QHP Annual Report and Delta Dental data can also be utilized	Ongoing
3. Encourage participation by dental professionals in state and local tobacco coalitions.		MDA, MDHA, Tobacco Free Michigan Action Coalition (TFMAC) and Oral Health Coalition Partners.	Increased participation by dental professionals	Ongoing
4. Explore grant opportunities for tobacco prevention, cessation and control activities.	Federal and foundation funding. Michigan Association of Health Plans (Taking on Tobacco).	Michigan Spit Tobacco Education Program Coordinator and the MDCH Tobacco Prevention Program.	Funding for tobacco related activities is obtained.	Ongoing

Funding Workgroup

Recommendation/Strategy: Creation of a Medicaid adult oral health benefit that ensures access and is consistent with high quality of care standards.

Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health. Poor oral health has been linked to health problems such as pre-term births, uncontrolled diabetes and heart disease. The elimination of the adult dental benefit will result in increased Medicaid medical costs since the services sought by individuals unable to get appropriate dental services are still covered by the Medicaid program.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Reinstate the Medicaid adult dental benefit.	$10 million in general fund dollars.	Michigan Department of Community Health	Benefit is reinstated	Fiscal Year 2005
2. Encourage MDCH and the state legislature to increase provider rates from current levels for services provided to Medicaid adults (approximately 32% of usual and customary rates) to 70% of Usual and Customary Rate (UCR).	Will be determined based on plans.	MDA MALPH MPCA	Bi-annual review of payment rates compared to UCR	Phase-in completed by Fiscal Year 2008

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
3. Create a plan to overcome challenges to raise reimbursement rates.	Meeting of partnership and facilitated discussion	MDA, MALPH and Michigan Primary Care Association	Plan created	February 2005
4. Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Initiated immediately with completion dependent on plan
5. Encourage MDCH to provide the local match required for local health departments to access Title V dollars.	1.2 million	Dental Clinics North/Michigan Association for Local Public Health	State funds provided for local match	Fiscal Year 2005
6. Work with the MDCH to modify the Medicaid oral health pediatric and adult benefits reflect the current standards of practice.	Staff time	Michigan Dental Association	Benefit reflects current standards of practice	Fiscal Year 2006
7. Support efforts to mandate oral health as part of the Medicaid package.	Commitment, passion and staff time	MPCA will work with NACHC and the ASTDD. MDA will work with ADA. MDHA will work with the ADHA.	Dental services are a mandatory benefit for Medicaid	Fiscal Year 2006

Recommendation/Strategy: Creation of a Medicaid pediatric oral health benefit that ensures access throughout the state and is consistent with high quality of care standards.

Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health. Michigan must commit itself to giving our children the best possible start at a healthy life.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Inventory strategies used across the country to increase access to oral health services for children.	Staff time	Michigan Primary Care Association	Inventory created	January 2005
2. Evaluate the strategies identified in Action Step 1 in addition to the following: 1) roll-out the Healthy Kids Dental to all counties and 2) increase provider rates from current levels (48% of UCR) to 70% of UCR and determine best possible strategy(s) for Michigan.	Meeting of partnership and facilitated discussion	Funding Workgroup	Common strategy is formed by partners	February 2005
3. Identify any legislative or administrative changes necessary to implement strategy.	Staff time	Michigan Department of Community Health	Potential challenges identified	March 2005

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
4. Implementation plan developed to overcome challenges identified in Action Step 3.	Meeting of partnership and facilitated discussion	MDA and Michigan Primary Care Association	Plan created	April 2005
5. Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Initiated immediately with completion dependent on plan

Recommendation/Strategy: Develop a system of care that ensures access to oral health services for low-income uninsured populations.
Rationale: Research has shown that poor oral health has a tremendous impact on an individual's overall health.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Inventory existing programs and resources in Michigan.	Staff time	Michigan Primary Care Association	Inventory created	January 2004
2. Research and inventory models that work across the country.	Staff time	Michigan Primary Care Association	Inventory created	February 2004
3. Look at employer incentives to provide dental coverage.	Staff time	Michigan Primary Care Association	Summary of options available	March 2005
4. Determine best possible strategy(s) for Michigan to increase access to oral health services	Meeting of partnership and facilitated discussion	Michigan Primary Care Association	Common strategy is formed by partners	April 2005
5. Identify any legislative or administrative changes necessary to implement strategy.	Staff time	Michigan Department of Community Health	Potential challenges identified	May 2005
6. Implementation plan developed to overcome challenges identified in Action Step 3.	Meeting of partnership and facilitated discussion	MDA and Michigan Primary Care Association	Plan created	June 2005

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
7. Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Initiated immediately with completion dependent on plan.

Workforce Workgroup

Recommendation/Strategy: Increase access to oral health services in medically underserved communities and to medically underserved populations by allowing the provision of high quality dental care through qualified health care providers.

Rationale: There exists a serious shortage of dentists willing to care for the uninsured and publicly insured populations. In addition, there are a number of communities without sufficient numbers of dentists to care for even the commercially insured population. This strategy will allow us to increase the number of people who receive regular, high quality oral health care from qualified professionals.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Inquire with potential partners to identify willingness to participate.	Staff time	MPCA	Partnership formed	September 2004
2. Research approaches used by other states to address access issues with current workforce.	Staff time	Michigan Primary Care Association	Summary of creative approaches	September 2004
3. Determine best possible strategy(s) for Michigan.	Meeting of partnership and facilitated discussion	Partnership	Common strategy is formed by partners	October 2004
4. Identify any legislative or administrative changes necessary to implement strategy.	Staff time	Michigan Department of Community Health	Potential challenges identified	December 2004
5. Implementation plan developed to overcome challenges identified in Action Step 4.	Meeting of partnership and facilitated discussion	Partnership	Plan created	February 2005

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
6. Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Dependent on plan
7. Periodic evaluation of progress and modification of strategies and/or implementation plan made as appropriate.	Meeting of partnership and facilitated discussion	Partnership	Quarterly meetings of the partnership	June 2005 September 2005 December 2005

Recommendation/Strategy: Develop and support incentive programs to attract oral health care professionals to underserved areas and to serve the medically underserved populations.

Rationale: There exists a serious shortage of dentists willing to care for the uninsured and publicly insured populations. In addition, there are a number of communities without sufficient numbers of dentists to care for even the commercially insured population. This strategy will allow us to increase the number of people who receive regular, high quality oral health care from qualified professionals.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Inventory existing state and federal incentive programs and include benefits/limitations and impact information.	Staff time	Michigan Primary Care Association	Inventory created	August 2004
2. Research approaches used by other states to address access issues with incentive programs	Staff time	Michigan Primary Care Association	Summary of creative approaches	October 2004
3. Determination of best possible strategy(s) for Michigan.	Meeting of workgroup and facilitated discussion	Partnership	Common strategy is identified	November 2004
4. Identify any legislative or administrative changes necessary to implement changes to existing programs or create new ones.	Staff time	Michigan Department of Community Health	Potential challenges identified	January 2004

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
5. Implementation plan developed to overcome challenges identified in	Meeting of work group and facilitated discussion	Partnership	Plan created	March 2005
6. Implementation plan initiated.	Dependent on plan	Each partner organization	Activities in plan completed	Dependent on plan
7. Periodic evaluation of progress and modification of strategies and/or implementation plan made as appropriate.	Meeting of partnership and facilitated discussion	Michigan Primary Care Association	Quarterly meetings of the partnership	June 2005 September 2005 December 2005

Recommendation/Strategy: Create and maintain a process for assessing and responding to supply and demand of the oral health workforce.

Rationale: Very little quantifiable information is gathered and analyzed on the amount of oral health resources currently available. Until we can determine what we already have, it will be difficult to gather enough momentum to change the system to better meet our needs.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Inventory other state's approaches for monitoring workforce supply and/or demand.	Staff time	Michigan Health Council	Inventory created	July 2004
2. Estimate resources required to implement most promising processes identified in Action Step 1.	Staff time	Michigan Department of Community Health	Resources estimated for most promising processes	August 2004
3. Determination of best possible process(s) for Michigan.	Meeting of work group and facilitated discussion	Michigan Department of Community Health and Michigan Health Council	Best process for Michigan is identified	September 2004
4. Identify any legislative or administrative changes necessary to implement identified strategy.	Staff time	Michigan Department of Community Health	Potential challenges identified	November 2004

5. Implementation plan developed.	Staff time	Michigan Department of Community Health	Plan created	March 2005
6. Implementation plan started.	Dependent on plan	Each partner organization	Activities in plan completed	Dependent on plan

Recommendation/Strategy: Develop a Dental Director leadership position to serve as the focal point of oral health activity for the state.
Rationale: There is a lack of leadership in oral health within the State of Michigan administration that can effectively work with all components of the health care system and training programs.

Action Step	Resources/Contribution Needed	Responsible Individual/ Organization	Monitoring Mechanism	Completion Date(s)
1. Initiate conversations with MDCH administration regarding Coalition's support for a Dental Director.	Staff time	Michigan Public Health Association – Oral Health Section	Conversations began	September 2004
2. Develop the coalition's wishlist for the Dental Director's position.	Staff time	Michigan Public Health Association – Oral Health Section	Wish list created	September 2004
3. Assist the MDCH as appropriate in this development.	Dependent on MDCH guidance	Oral Health Coalition	Dependent on MDCH guidance	Dependent on MDCH guidance